Joint Action on integrating prevention, testing and linkage to care strategies across HIV, viral hepatitis, TB and STIs in Europe

D6.2 Consensus recommendations for collection and integration of CBVCT testing and linkage to care data into national surveillance systems for HIV, viral hepatitis and STIs

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1. Background

Timely diagnosis of HIV infection, other sexually transmitted infections (STIs) such as syphilis, gonorrhoea and chlamydia infection, hepatitis B and hepatitis C is a precondition for referral to treatment which is essential to decrease respective morbidity and mortality and prevent onward transmission of these infections. Evidence-based national testing policies and programmes aiming to reach and test those at risk for these infections have become a public health priority.

Initiatives to improve testing and linkage to care data monitoring have historically focussed on HIV. In October 2016, the European Centre for Disease Prevention and Control (ECDC) convened an expert consultation with representatives from national institutions, community organisations, and healthcare workers from 14 Member States and international organisations, to explore how to strengthen HIV testing and linkage to care monitoring in the European Union/European Economic Area (EU/EEA) countries [1]. The consensus was that improving testing policies, planning, resource allocation and program performance requires timely, accurate and high-quality data on testing and linkage to care for HIV locally, nationally and within the European region [1]. Recently, the focus has been broadened to include hepatitis B and hepatitis C testing and ECDC has published Public health guidance on HIV, hepatitis B and C testing in the EU/EEA [2] that recommended testing to be conducted not only in health care settings but also in other settings such as prisons, drug and harm reduction services, in the community, and by self-sampling and self-testing. The document also emphasized that and effective national testing strategy, including monitoring and evaluation (M&E) framework, is critical in responding to hepatitis B, hepatitis C and HIV infection.

Community-based voluntary counselling and testing (CBVCT) has been shown to contribute to a sizeable proportion of new HIV diagnoses, especially among men who have sex with men (MSM) [3]. CBVCT services can reach key populations at higher risk of HIV infection and STIs such as MSM, sex workers (SW), people who inject drugs (PWID) and migrants. Guidelines including core indicators to M&E CBVCT for HIV have been developed to help CBVCT services to assess and improve the quality of their services [4]. They have been widely used by CBVCT for HIV services throughout Europe which contributed to the quality and consistency of the data collected for M&E purposes and enhanced the accuracy of conclusions drawn from it at national and European level [5,6]. Since M&E is an essential component of any effective national testing programme [2], it is vital that in countries that provide CBVCT at least some core data about M&E of testing at CBVCT services are integrated into respective national surveillance and M&E systems.

The "Joint Action on integrating prevention, testing and linkage to care strategies across HIV, viral hepatitis, tuberculosis and STIs in Europe" (INTEGRATE) has the overall objective to increase early diagnosis and linkage to prevention and care not only for HIV and viral hepatitis, but also for tuberculosis and STIs in EU Member States by 2020. One of the objectives of the work package 6 (WP6) "Monitoring and evaluation of HIV, STIs and HCV testing and linkage to care" was to support the integration of testing and linkage to care data from CBVCT services into national surveillance and M&E systems for HIV, STIs, hepatitis B and hepatitis C virus. The respective deliverable is this document, the "Consensus recommendations for collection and integration of CBVCT testing and linkage to care data into national surveillance systems for HIV, viral hepatitis and STIs".

2. Aims and objectives

With the aim to contribute to early diagnosis and linkage to care for HIV, STIs and hepatitis B and hepatitis C, our objective was to prepare "Consensus recommendations for collection and integration of CBVCT testing and linkage to care data into national surveillance systems for HIV, viral hepatitis and STIs" and thus support EU/EEA countries to have better informed CBVCT policies and programmes for all these infections.

Our more specific objective was to identify and agree on the list of core CBVCT M&E indicators to be proposed to be integrated into national surveillance and M&E systems for HIV, STIs and hepatitis B and C. Some of these CBVCT M&E indicators would be relevant only for some of these different infections.

Additional objective was to provide some additional recommendations to CBVCT services and national surveillance and M&E institutions based on experiences from pilots in six countries.

3. Methodology

Two consensus meetings with all WP6 partners, jointly with public health institutes and CBVCT services representatives were held in Barcelona, before and after the pilot activities in each of the 6 participating countries (Estonia, Slovakia, Serbia, Poland, Slovenia and Spain).

The first consensus meeting with representatives from CBVCT services, national surveillance and M&E agencies from five of the 6 pilot countries (Serbia, Slovakia, Slovenia, Poland, and Spain) was held in Barcelona in December 2018. NIJZ and CEEISCAT proposed a preliminary set of CBVCT M&E indicators for HIV, STIs and hepatitis B and C to be integrated into national surveillance and M&E systems for these infections. The proposal was based on outcomes of Euro HIV EDAT project [4–6], Dublin Declaration Monitoring questionnaire 2018 [7] and ECDC Public health guidance on HIV, hepatitis B and C testing in the EU/EEA [2]. At the meeting a consensus was reached on a preliminary set of core indicators for M&E CBVCT for HIV, viral hepatitis and STIs to be integrated into national surveillance and M&E systems. A minimal list and extended list of indicators was proposed. Planning for activities to pilot respective data collection in pilot countries started at the meeting. After the meeting, in December 2018, a common protocol for the WP 6.3 pilots was finalised.

Each WP6 partner (ICO-CEEISCAT, IPH, NAC, NIJZ, SMU, and TAI) coordinated the implementation of respective pilot activities in their country during the period from 1st January 2019 to 31st June 2019. Some pilot activities were extended to 31st August 2019. Standardised end-of-pilot draft reports were prepared by all partners using a template prepared by ICO-CEEISCAT and submitted to ICO-CEEISCAT in November 2019.

The second consensus meeting with representatives from CBVCT services, national surveillance and M&E agencies from all pilot countries (Estonia, Serbia, Slovakia, Slovenia, Poland, and Spain) was held in Barcelona in November 2019. The results of pilots in all six pilot countries that lead towards the integration of CBVCT testing data indicators into the national surveillance and M&E systems were presented and discussed. The final consensus on a set of core indicators on HIV, viral hepatitis and STI testing and linkage to care from CBVCT services to be integrated into national surveillance and M&E systems was reached. A thematic analysis of the facilitators and barriers faced by each partner in implementing pilot activities was conducted to inform the recommendations. Consensus on the final recommendations presented in this report was reached.

Representatives from five pilot countries (Estonia, Serbia, Slovenia, Poland, and Spain) also participated in the ECDC Dublin Declaration Advisory Group meeting held in ECDC in December 2019. The proposed set of core indicators on HIV, viral hepatitis and STIs testing and linkage to care from CBVCT services to be integrated into national surveillance and M&E systems was discussed. The participants of the Dublin Declaration Advisory Group consented to the proposed list to be included into the "Consensus recommendations for collection and integration of CBVCT testing and linkage to care data into national surveillance systems for HIV, viral hepatitis and STIs", the WP 6 deliverable. In addition, a proposal to plan for ECDC coordinated data collection for CBVCT for HIV in EU/EEA countries with the Dublin Declaration Questionnaire 2020 was discussed. The estimates for the majority of the proposed minimal list of M&E HIV testing and linkage to care from CBVCT services to be integrated into national surveillance and M&E systems will probably be also be collected from EU/EEA countries by ECDC with the Dublin Declaration Questionnaire 2020.

During the review process of this document by the INTEGRATE Steering Committee there was a suggestion to add some indicators to measure the integrated testing across diseases areas, so two extra indicators were included in the extended set (Proportion of clients tested for HIV also tested for at least one more infection, either STI or hepatitis B or hepatitis C; Proportion of clients with a reactive HIV test with at least one more reactive result for one more infection, either STI or hepatitis B or hepatitis C).

4. Recommended indicators for M&E of CBVCT for HIV, STIs, hepatitis B and C to be integrated into national surveillance and M&E systems

We recommend that the following indicators for M&E of CBVCT for HIV, STIs, hepatitis B and C estimates are obtained annually by the national surveillance and M&E institutions in EU/EEA member states. In addition to overall estimates, we recommend that estimates are also obtained for key populations tested at CBVCT services (MSM, PWID, SW and migrants) and are also disaggregated by sex and age group (at least < 25 years old and 25+ years old). If considered appropriate, these estimates can also be obtained for shorter periods, for example monthly. Such data will support EU/EEA countries to have better informed CBVCT policies and programmes and will contribute to early diagnosis and linkage to care for HIV, STIs and hepatitis B and hepatitis C among the key populations such as MSM, PWID, SW, and migrants.

The below list of CBVCT M&E indicators to be integrated into national surveillance and M&E systems is divided into the minimum set and the extended set of CBVCT M&E indicators. All CBVCT M&E indicators in the minimum set are relevant for HIV infection, hepatitis B, hepatitis C and all STIs tested for at CBVCT services. Some of the CBVCT M&E indicators in the extended set are only relevant for some of these infections. We recommend to all EU/EEA countries to collect the data for at least the minimum set of CBVCT M&E indicators for all infections tested for at CBVCT services. If resources permit and according to national priorities, we recommend that EU/EEA member states also consider collecting annual estimates for CBVCT M&E indicators from the extended list.

MINIMUM SET OF CBVCT M&E INDICATORS FOR HIV, HEPATITIS B AND C AND STIs

1. NUMBER OF TESTS

Number of tests	
Definition	Number of tests performed
Comments	The number of test corresponds to the number of testing events for a particular infection. Tests used at CBVCT services are most often screening tests. Only rarely confirmatory tests are used. Number of tests is used as a denominator for some of the testing M&E indicators listed below.

2. NUMBER OF CLIENTS TESTED

Number of clients tested	
Definition	Number of clients tested
Comments	The number of clients tested corresponds to the number of clients tested for a particular infection. Number of clients tested is used as a denominator for some of the testing M&E indicators listed below.

3. REACTIVITY RATE

a. REACTIVITY RATE OF TESTS

Reactivity rate of tests	
Definition	Proportion (%) of reactive screening test results among all tests performed
Numerator	Number of tests with reactive screening test result
Denominator	Number of tests performed
Calculation	(Number of tests with reactive screening test result) / (Number of tests performed) *100

b. REACTIVITY RATE FOR CLIENTS

Reactivity rate for clients	
Definition	Proportion (%) of clients with reactive screening test result among all clients tested
Numerator	Number of clients with reactive screening test result
Denominator	Number of clients tested
Calculation	(Number of clients with a reactive screening test result) / (Number of clients tested) *100

4. POSITIVITY/ACTIVE INFECTION RATE

a. POSITIVITY/ACTIVE INFECTION RATE OF TESTS

Positivity/active infection rate of tests	
Definition	Proportion (%) of confirmed positive test results (confirmed active infections) among all tests performed
Numerator	Number of confirmed positive test results (confirmed active infections)
Denominator	Number of tests performed
Calculation	(Number of confirmed positive tests results (confirmed active infections)) / (Number of tests performed) *100

b. POSITIVITY/ACTIVE INFECTION RATE FOR CLIENTS

Positivity/active infection rate for clients	
Definition	Proportion (%) of clients with a confirmed positive test result (confirmed active infection) among all clients tested
Numerator	Number of clients with a confirmed positive test result (confirmed active infection)
Denominator	Number of clients tested
Calculation	(Number of clients with a positive confirmed test result (confirmed active infection)) / (Number of clients tested) *100

5. LINKAGE TO CARE RATE

a. LINKAGE TO CARE FOR CLIENTS WITH A REACTIVE SCREENING TEST RESULT

Linkage to care for clients with a reactive screening test result	
Definition	Proportion (%) of clients with a reactive screening test result that have been linked to care among all clients tested
Numerator	Number of clients with a reactive screening test result that have been linked to care
Denominator	Number of clients tested
Calculation	(Number of clients with a reactive screening test result that have been linked to care) / (Number of clients tested) *100
Comments	Infection specific definitions for linkage to care from CBVCT service agreed upon in each country should be used. For example, for HIV, linkage to care can be defined as linkage to specialist HIV health care within a month after first reactive screening test for HIV at CBVCT service; or, alternative definition could be linkage to confirmatory testing for HIV within a month after first reactive screening test for HIV at CBVCT service.

b. LINKAGE TO CARE FOR CLIENTS WITH A POSITIVE TEST RESULT (ACTIVE INFECTION)

Proportion of clients with a positive test result linked to care	
Definition	Proportion (%) of clients with a positive test result (active infection) that have been linked to care among all clients tested
Numerator	Number of clients with a positive test result (active infection)
Denominator	Number of clients tested
Calculation	(Number of clients with a positive test result (active infection)) / (Number of clients tested) *100
Comments	Positive test result is a positive result of a confirmatory test. Infection specific definitions for linkage to care from CBVCT service agreed upon in each country should be used. For example, for HIV, linkage to care can be defined as linkage to specialist HIV health care within a month after first reactive screening test for HIV at CBVCT service.

6. PROPORTION OF ALL NEW DIAGNOSES WITH FIRST REACTIVE OR POSITIVE TEST AT CBVCT

Proportion of all new diagnoses with first reactive test at CBVCT	
Definition	Proportion (%) of clients with new diagnosis with first reactive (or positive) test result at a CBVCT service
Numerator	Number of clients with a new diagnosis with first reactive (or positive) test result at a CBVCT service
Denominator	Number of all individuals in a country with new diagnosis
Calculation	(Number of clients with new diagnosis with first reactive (or positive) test result at a CBVCT service) / (Number of all individuals in a country with new diagnosis) *100
Comment	Tests used at CBVCT services are most often screening tests. Only rarely confirmatory tests are used. In the latter case, positive result of the confirmatory test could be used.

EXTENDED SET OF CBVCT M&E INDICATORS FOR HIV, HEPATITIS AND STIs

7. PROPORTION OF CLIENTS WHO HAVE BEEN TESTED PREVIOUSLY

Proportion of clients who reported to have been tested previously	
Definition	Proportion (%) of clients who reported to have been tested previously among all clients tested
Numerator	Number of clients who reported to have been tested previously
Denominator	Number of clients tested
Calculation	(Number of clients who reported to have been tested previously) / (Number of clients tested) *100

8. PROPORTION OF CLIENTS WHO HAVE BEEN TESTED DURING PRECEDING 12 MONTHS

Proportion of clients who reported to have been tested during preceding 12 months	
Definition	Proportion (%) of clients who reported to have been tested during preceding 12 months among all clients tested
Numerator	Number of clients who reported to have been tested during preceding 12 months
Denominator	Number of clients tested
Calculation	(Number of clients who reported to have been tested during preceding 12 months) / (Number of clients tested) *100

9. PROPORTION OF CLIENTS WITH REACTIVE SCREENING TEST RESULT TESTED WITH A CONFIRMATORY TEST

Proportion of clients with reactive screening test result tested with a confirmatory test	
Definition	Proportion (%) of clients with reactive screening test result who have been tested with confirmatory test among all clients with a reactive screening test result
Numerator	Number of clients with reactive screening test result who have been tested with confirmatory test
Denominator	Number of clients with a reactive screening test result
Calculation	(Number of clients with reactive screening test result who have been tested with confirmatory test) / (Number of clients with a reactive screening test result) *100

10. PROPORTION OF CLIENTS TESTED AT SPECIFIC VENUES: CBVCT PREMISES, OUTREACH, SELF-SAMPLING,...

Proportion of clients tested at specific venues: office, outreach, self sampling, …	
Definition	Proportion (%) of clients tested at specific venues (office, outreach, self-sampling, …) among all clients tested
Numerator	Number of clients tested at specific venues
Denominator	Number of clients tested
Calculation	(Number of clients tested at specific venues) / (Number of clients tested) *100

11. PROPORTION OF CLIENTS TESTED FOR HIV ALSO TESTED FOR AT LEAST ONE MORE INFECTION, EITHER STI OR HEPATITIS B OR HEPATITIS C

Proportion of clients tested for HIV also tested for at least one more infection, either STI or hepatitis B or hepatitis C	
Definition	Proportion (%) of clients tested for HIV also tested for at least one more infection, either STI (syphilis, gonorrhoea or chlamydia) or hepatitis B or hepatitis C, at the same testing visit
Numerator	Number of clients tested for HIV also tested for at least one more infection, either STI or hepatitis B or hepatitis C
Denominator	Number of clients tested for HIV
Calculation	(Number of clients tested for HIV also tested for at least one more infection, either STI or hepatitis B or hepatitis C) / (Number of clients tested for HIV) *100
Comment	The addition of this indicator was suggested during the review process by the INTEGRATE Steering Committee, in order to reflect the integrated testing across diseases areas.

12. PROPORTION OF CLIENTS WITH A REACTIVE HIV TEST WITH AT LEAST ONE MORE REACTIVE RESULT FOR ONE MORE INFECTION, EITHER STI OR HEPATITIS B OR HEPATITIS C

Proportion of clients with a reactive HIV test with at least one more reactive result for one more infection, either STI or hepatitis B or hepatitis C	
Definition	Proportion (%) of clients with a reactive HIV test result with at least one more reactive result for one more infection, either STI (syphilis, gonorrhoea or chlamydia) or hepatitis B or hepatitis C at the same testing visit
Numerator	Number of clients with a reactive HIV test result with at least one more reactive result for one more infection, either STI or hepatitis B or hepatitis C
Denominator	Number of clients with reactive HIV test
Calculation	(Number of clients with a reactive HIV test result with at least one more reactive result for one more infection, either STI or hepatitis B or hepatitis C) / (Number of clients tested) *100
Comment	The addition of this indicator was suggested during the review process by the INTEGRATE Steering Committee, in order to reflect the integrated testing across diseases areas.

EXTENDED SET OF CBVCT M&E INDICATORS FOR HEPATITIS AND STIs

13.   PROPORTION OF CLIENTS WHO REPORTED TO HAVE BEEN PREVIOUSLY DIAGNOSED

Proportion of clients who reported to have been previously diagnosed	
Definition	Proportion (%) of clients who reported to have been previously diagnosed among all clients tested
Numerator	Number of clients who reported to have been previously diagnosed
Denominator	Number of clients tested
Calculation	(Number of clients who reported to have been previously diagnosed) / (Number of clients tested) *100

We recommend that the estimates for any of the above listed indicators for M&E of CBVCT for HIV, STIs, hepatitis B and C obtained annually by the national surveillance and M&E institutions are published together with contextual information about CBVCT services in respective annual national surveillance and M&E reports.

Collection of at least some of these standardised CBVCT M&E indicators data in EU/EEA countries by ECDC would contribute to the availability of comparable information about the impact of CBVCT services in EU/EEA countries and better informed regional testing policies for HIV, STIs and hepatitis B and C and to early diagnosis and linkage to care for all these infections among the key populations such as MSM, PWID, SW, and migrants in the region.

The estimates for the majority of the proposed minimal list of M&E HIV testing and linkage to care from CBVCT services to be integrated into national surveillance and M&E systems will be also be collected from EU/EEA countries by ECDC with the Dublin Declaration Questionnaire 2020. The indicators selected are:

- INDICATOR 1. NUMBER OF TESTS
- INDICATOR 2. NUMBER OF CLIENTS TESTED
- INDICATOR 3.A REACTIVITY RATE OF TESTS
- INDICATOR 3.B REACTIVITY RATE FOR CLIENTS
- INDICATOR 5. LINKAGE TO CARE RATE
- INDICATOR 6. PROPORTION OF ALL NEW DIAGNOSES WITH FIRST REACTIVE OR POSITIVE TEST AT CBVCT

5. Recommendations for collection and integration of CBVCT testing and linkage to care data into national surveillance systems for HIV, viral hepatitis and STIs

RECOMMENDATION 1. COUNTRY CONTEXT

RECOMMENDATION 1. To interpret CBVCT M&E data, the context regarding availability of tests for CBVCT services, barriers to testing and treatment should be taken into account

The WP6.3 pilots drew attention to the barriers faced by people trying to access testing and treatment, especially people from key populations most at risk for these infections. Slovakia and Poland both reported regulations that prevent PWID diagnosed with hepatitis C from accessing treatment, leading to questions around the ethics of testing people who cannot access treatment when diagnosed with infection. CBVCT services should have access to tests and all clients with a reactive test should be linked to appropriate care and treatment.

RECOMMENDATION 2. QUALITY ASSURANCE

RECOMMENDATION 2. Quality assurance of CBVCT services should be supported

National surveillance and M&E institutions should consider supporting CBVCT services to collect good quality data. Quality assurance in CBVCT services should extend beyond data collection processes and incorporate good testing practices, capacity building for staff and volunteers as well as quality assurance of testing kits. External quality assurance support can be an incentive for CBVCT services to submit CBVCT M&E data to the national surveillance and M&E system. One objective of the pilot in Serbia was to compare different reporting methods to decide about the most appropriate data collection mode for the integration of CBVCT M&E data into the national surveillance and M&E system.

RECOMMENDATION 3. RECOGNITION OF CONTRIBUTION OF CBVCT SERVICES

RECOMMENDATION 3. The contribution of CBVCT services to early diagnosis should be recognised

Integrating M&E CBVCT service data into respective national surveillance and M&E systems for these infections and disseminating reports will increase recognition of the contribution of CBVCT services to early diagnosis for these infections. The ECDC's Dublin Declaration Advisory Group has made steps towards increasing recognition of CBVCT for HIV services at the European level by including questions about community-based testing in their Dublin Declaration Monitoring Questionnaire (survey) in 2018 and 2020.

RECOMMENDATION 4. USE OF UNIQUE CLIENT IDENTIFIER

RECOMMENDATION 4. A unique client identifier can be used by CBVCT services to monitor repeat testers

Use of a unique client identifier is an option for CBVCT services so that they do not have to collect personal information about clients such as names. The unique identifier can be an alphanumeric code based on a number of personal questions which uniquely identify the client while ensuring that the client does not need to remember their code for different visits. Clients who do not wish to share personal information should be allowed to access testing nevertheless.

RECOMMENDATION 5. USE OF STANDARDIZED SET OF INDICATORS

RECOMMENDATION 4. Using a standardised set of indicators is necessary to ensure data is comparable within a country and between countries

To ensure CBVCT M&E data is comparable among CBVCT services within a country and between countries it is necessary to use a standardized set of indicators. A minimum and extended set of CBVCT M&E indicators has been agreed upon by the WP6 partners. Pilot activities have demonstrated that the data necessary to obtain estimates for these indicators is feasible to collect in the community setting. See chapter 3 for the list of recommended CBVCT M&E indicators.

When possible, the use of a standardized data collection tool makes it easier to calculate the estimates for the standardised set of CBVCT M&E indicators.

RECOMMENDATION 6. DO NOT DUPLICATE REPORTING REQUIREMENTS

RECOMMENDATION 6. Before implementing new reporting requirements, national surveillance and M&E institutions should understand what data CBVCT services are already collecting and if it is compatible with the recommended indicators

CBVCT services often already collect data necessary to estimate the recommended set of CBVCT M&E indicators. National surveillance and M&E institutions should try to use available data as far as possible and not unnecessarily increase the reporting requirements. Adding unnecessary reporting requirements can waste the CBVCT services' resources and can lead to damaging relations between the national surveillance and M&E institutions and CBVCT services.

RECOMMENDATION 7. INDICATOR "NEW DIAGNOSIS WITH FIRST REACTIVE TEST AT CBVCT SERVICE"

RECOMMENDATION 6. The indicator "Proportion of new diagnosis with first reactive test at CBVCT service" is essential to understand the contribution of CBVCT services to early diagnosis

It's important to collect the indicator "Proportion of all new diagnosis in a country with a first reactive test at a CBVCT service" in order to understand the contribution of CBVCT services to early diagnosis of these infections.

The data for estimating this indicator can be collected in one of the following ways:

1. CBVCT services and surveillance system use a common unique identifier to identify patients linked to care from CBVCT services
2. CBVCT service collects self-reporting data from clients about confirmatory testing and linkage to care.
3. Indicator is estimated by triangulating the information about the number of reactive tests in CBVCT services and the number of reported new diagnoses to the national surveillance and M&E institution each year.

The method of collecting the data to estimate this indicator will depend on the country context.

RECOMMENDATION 8. COOPERATION OF ALL PARTIES

RECOMMENDATION 8. All stakeholders must "buy in" to the objective of integrating data

Integrating CBVCT M&E data into the national surveillance and M&E system requires the cooperation of all stakeholders. Clear common goals can facilitate this. For example production of an annual surveillance and M&E report for respective infections that include data about M&E of CBVCT services which is publicly available online and can be utilised by the CBVCT services can contribute to better collaboration.

RECOMMENDATION 9. USE OF ONLINE DATA COLLECTION

RECOMMENDATION 9. The use of online data collection which the national surveillance and M&E system has access to can reduce reporting burden

There are free tools for data collection that can be used by CBVCT services and, with the agreement of CBVCT services, sent to national surveillance.

Using an online tool which the national surveillance system has access to can reduce reporting burden and ensure data is standardised. The COBATEST Network has a free data collection tool (access through www.cobatest.org), which is used by the Catalan Network of CBVCT services (DEVO) so that data is harmonised and can be collected and analysed centrally without burdening CBVCT services with extra reporting tasks.

RECOMMENDATION 10. POSSIBILITY OF SHARING DIRECTLY INDICATORS INSTEAD OF CASE-BASED DATA

Recommendation 10. Countries facing problems with data protection legislation can collect estimates for the indicators from CBVCT services instead of collecting disaggregated (case-based) data

In the light of the EU General Data Protection Regulation (GDPR), sharing case-based data with the national surveillance and M&E institution may present a problem for CBVCT services who do not ask the consent of clients to do so. An alternative, instead of sharing disaggregates (case-base) data with the national surveillance and M&E institution, is that CBVCT service estimates the CBVCT M&E indicators and submits these estimates to the national surveillance and M&E institution. CBVCT services should be supported to ensure they can estimate these indicators correctly.

During the pilot in Slovenia such an approach was successfully implemented. The Slovenian CBVCT service will continue to annually submit the estimates for all the CBVCT M&E indicators agreed upon for all the infections tested for at the CBVCT service to the National Institute of Public Health.

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Abbreviations

- HIV: Human immunodeficiency virus
- STIs: Sexual transmitted infections
- ECDC: European Centre for Disease Prevention and Control
- EU/EEA: European Union/European Economic Area
- CBVCT: Community-based voluntary counselling and testing
- MSM: Men who have sex with men
- SW: Sex workers
- PWID: People who inject drugs
- M&E: Monitoring and evaluation
- WP: Work Package
- GDPR: General Data Protection Regulation

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Croatian association for HIV and viral hepatitis

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Health Promotion and Disease Prevention

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National AIDS Centre Agency of the Ministry of Health

Romania

"Victor Babes" Clinical Hospital of Infectious Diseases and Pneumophtisiology Craiova

"Marius Nasta" Pneumophtisiology Institute

Institute of Public Health of Serbia "Dr Milan Jovanovic Batut"

Slovakia

Slovak Medical University in Bratislava

Slovenia

National Institute of Public Health Nacionalni inštitut za javno zdravje

Spain

Centre d'Estudis Epidemiològics sobre les ITS i Sida de Catalunya

Consorci Institut d'Investigacions Biomèdicas August Pi i Sunyer

Instituto de salud pública y laboral de Navarra

United Kingdom

Public Health England